DMB-OSE 2209
Revised 12/18/2012

Office of the State Employer

REQUEST FOR AT-RISK ERGONOMIC ASSESSMENT

EMPLOYEE INFORMATION

EMPLOYEE NAME	EMPLOYEE ID #	DATE OF BIRTH	WORK ☎	EMAIL ADDRESS

JOB TITLE	WORK ADDRESS TO INCLUDE CITY/STATE/ZIP	BUILDING/FLOOR	BARGAINING UNIT

COUNTY	SUPERVISOR NAME	SUPERVISOR ☎	SUPERVISOR EMAIL ADDRESS

DISCLOSURE STATEMENT

- To be valid, this request and release must be filled out completely and returned or forwarded to the Department Designated Appointing Authority Representative for consideration and approval. ***Note**: a faxed or electronic copy of this request and authorization to release information shall be treated as an original/valid document.*
- Failure to provide a signed request and release to the Department Designated Appointing Authority Representative will prevent the At-Risk Ergonomic Assessment from being processed.
- Records released to the Department Designated Appointing Authority Representative, Civil Service Commission (CSC), the Office of the State Employer (OSE), Michigan Rehabilitation Services/Accommodations Center (MRS), Department of Technology, Management, and Budget (DTMB) or any other necessary party to process the request will be handled in a confidential manner.
- OSE is committed to providing access and disability accommodations in its programs, activities, and materials. Please call (517) 373-7400 to request accommodation or to obtain materials in an alternate format. Documentation of disability may be required.

AUTHORIZATION TO RELEASE INFORMATION

- My signature below authorizes the Department Designated Appointing Authority Representative, CSC, OSE, MRS, DTMB, or any other necessary party to discuss my request or share the accompanying medical documentation for the purpose of addressing my At-Risk Ergonomic Assessment.
- This request and release expires upon conclusion of my At-Risk Ergonomic Assessment unless I otherwise revoke it sooner. I understand that if I revoke this request and release, I must do so in writing to the Department Designated Appointing Authority and/or the OSE. ***Note**: revocation requests will take effect on the date the written notification is received; revocations will not apply to records that have already been released.*

Employee Signature _____ Date _____

APPOINTING AUTHORITY INFORMATION AND APPROVAL

All At-Risk Ergonomic Requests require a willing employee, a referral from the Department Designated Appointing Authority Representative, and recent medical documentation from a licensed or board certified physician that includes a formal diagnosis/relevant medical facts to support the need for the At-Risk Assessment. Recent medical is defined as a script, letterhead, or other documentation signed by an MD or DO within the last 60 days.

The cost of these assessments is generally paid for by the OSE, whereas the responsibility to acquire and implement applicable equipment and/or workstation adjustments is the responsibility of the employee's department, division, or office. Basic ergonomic accessories or adjustments can be implemented without initiating the Disability Accommodation process. OSE's At-Risk Ergonomic Assessment Program is not intended to address return-to-work situations, work-related injuries, or Disability Accommodation Requests based on a medical need. Please contact the OSE at (517) 373-7400 with any questions.

Submit completed At-Risk Ergonomic Requests and supporting medical documentation to the OSE via email at DMB-OSE@michigan.gov.

DEPARTMENT/AGENCY	CONTACT NAME	EMAIL ADDRESS	WORK ☎

REQUESTED SERVICE(S)

- ☐ Assistive Technology Assessment
- ☐ Chair Assessment Only
- ☐ Vehicle Assessment
- ☐ Other Assessment:
- ☐ Chair and Work Station Assessment
- ☐ Follow-up Assessment
- ☐ Work Station Assessment Only

Department Designated Appointing Authority Representative Signature _____ Date _____

FOR OSE USE ONLY

Date OSE Received: ____/____/____

OSE Referral #: _____

Request for Assessment: ☐ Approved ☐ Denied ☐ Withdrawn

Date: ____/____/____